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IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

SHERLEEN WYNN,

Plaintiff,

JUDGE McMANAMON
CASE NO. 187066

-vs-

CARL A. ROBSON, M.D. AND
L & D FAMILY MEDICINE,

Defendants.

Doc. 370

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Deposition of ERWIN R. RABIN, M.D., taken as if upon cross-examination before Aneta I. Fine, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the Meridia Huron Hospital, 13951 Terrace Road, Cleveland, Ohio, at 5:30 p.m. on Thursday, May 16, 1991, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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On behalf of the Defendant
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ERWIN R. RABIN, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF ERWIN R. RABIN, M.D.

BY MR. KAMPINSKI:

Q. Okay. Doctor, would you state your full name, please?

A. Erwin R. Rabin.

Q. And spell your last name, doctor.

A. R A B I N.

Q. I'm going to ask you a number of questions this afternoon. If you don't understand any of them, please tell me; I'll be happy to rephrase anything you don't understand.

When you respond to my questions please do so verbally. She's going to take down everything we say, she can't take down a nod of your head, okay?

A. We'll try to follow those explicit instructions.

Q. Thank you. Do you have a CV, doctor?

A. Just so happen to have gotten a CV prepared.

Q. Thank you. To what extent have you interacted

with Dr. Siegler in a professional context? I mean I know that the two of you are part of or members of the same groups, correct?

A. We are pathologists, and we have seen each other on occasion at pathology meetings, local pathology meetings.

Q. Which group would that be, doctor?

A. Cleveland Society of Pathology.

Q. Okay. And have the two of you held office in that group?

A. I held office. I don't know if Dr. Siegler did.

Q. What office did you hold?

A. President.

Q. President. And when was that --

A. It's --

Q. I haven't had a chance it absorb all this obviously.

A. Let me go back and refresh my memory, if you want, It says '84, '85.

Q. Okay. And did Dr. Siegler hold any office at that time?

A. I don't believe so. I don't believe he has been very active in that group.

Q. Okay. As president would you have been elected by the members of that group?

A. Yes.
Q. And did you have any interaction with him while you were president as you recall?
A. Very little. Nothing of any consequence.
Q. Have you been on any committees in that group together?
A. Not that I'm aware of. We were working with Blue Cross in terms of getting some reimbursement. I think he was interested in that although I am not sure that he was active, actively participating.
Q. When was that?
A. That was during my presidency, in '84, '85.
Q. In other words, trying to establish some type of policy as it related to how you'd be paid?
A. Right. Reimbursements. That's my recollection.
Q. Was there a formal committee?
A. I don't remember. But there were a number of active members that were working with me in that area.
Q. And you seem to think that Dr. Siegler was active?
A. Was not.
Q. Was not active?
A. But he may have given funds for that endeavor.

I don't remember exactly.

Q. I see. Any other organizations that the two of you belong to?

A. We're both members of the Jewish Community Center, and I see him there infrequently, but I see him in the health club infrequently and I think we both belong to the same temple.

Q. Which is?

A. The Temple.

Q. The Temple. Do you socialize together?

A. No. We don't, not at all.

Q. How old are you, doctor?

A. I was recently 60.

Q. Okay. Do you know how old Dr. Siegler is?

A. No. But he -- I think he is of that vintage.

Q. Do any of your family members socialize with any family members of his?

A. No.

Q. Children, grandchildren, wives?

A. No.

Q. Okay. You live where, doctor?

A. Bratenahl Place, 2 Bratenahl Place.

Q. All right. You started here at Huron Road when?

A. '76.

Q. All right. And Dr. Siegler had been here right

before that time?

A. That is correct.

Q. Did you take over his position?

A. I did.

Q. And was there any interrelationship at that time as far as the transition?

A. Not that I remember. I have been told that perhaps he stayed on for a week or so to help me but I have no recollection of that.

Q. Okay. Have you ever acted as an expert witness before, doctor'?

A. Yes.

Q. All right. And how many times would you say you have?

A. Very few.

Q. Well, are we talking five, ten, 20?

A. Less than five,

Q. Okay. And have they been for the defendant?

A. For the defendant? No, I think that acted as an expert witness a couple of times and plaintiffs in terms of asbestos cases, although just once that I recall, and then I was a deputy coroner in Topeka, Kansas in '74 to '76, and I think I made a few court appearances regarding my duties there, just how many, I don't remember at this

point, but not very many.

Q. Okay. How about since you have been here in Cleveland, other than the asbestos case?

A. I have testified at some -- on some laboratory examinations relating to alleged rape hut I was never, I think, deemed an expert witness there because I was never reimbursed in that manner.

Q. Okay. How about in any malpractice cases, have you ever testified?

A. Not that I'm aware.

Q. All right.

A. I will have to think about that for a minute, that I'm aware of.

Q. All right. Have you yourself ever been sued?

A. You know, when I was a resident I did in New Haven, Connecticut. I think that I did give some testimony relating to a specimen relating to an abortion. If that was a mal -- I am not sure that's a malpractice case.

Q. Okay.

A. But that's searching.

Q. Okay.

A. Okay.

Q. Have you yourself ever been a defendant in a lawsuit?

MR. GROEDEL: Objection. You may answer.

A. Okay. I was a defendant in a lawsuit in Topeka, Kansas for an event that occurred two years prior to myself joining this group. So I really wasn't involved in the incident in any way, shape or form, and I deeply resented having been named on that but I was still part of this group and such was named.

Q. I see. So all the members of the group were named?

A. Were named. And I was named. Whatever happened in that case, I don't know, but I left Kansas and I was able to sell my house so something happened and I was not held liable for that in any way, shape or form, or at least maybe they settled it. I have never really realized what transpired on that.

Q. You are not relating your ability to sell your home to the fact that you got out?

A. Well, I think that if there was some type of judgment on myself it would have been difficult for me to --

Q. Well, did you ever go to court?

A. No.

Q. I mean I assume there was insurance coverage for your group?
A. Absolutely, right. But I don't know what transpired but during the course of that action it would have been difficult for me to think to sell my house, from what I gather. Because I think we had a potential buyer at the time.
Q. Of the group?
A. No, for the house. Those are ramblings.
Q. Were the allegations against your group failure to appropriateiy diagnose slides?
A. Was a blood bank incident.
Q. I see.
A. Mismatch, transfusion.
Q. Okay.
A. Very serious.
Q. All right. Okay. Give me just one moment to look through this.
A. Go right ahead.
Q. It indicates you are the chairman in the Department of Pathology from '76 to the present?
A. Correct.
Q. All right. What does the Department of Pathology comprise here? I mean, for example, how many physicians are employed by the

Department of Pathology?

A. At the present time I have one partner so there would be two physicians in our group.

Q. Okay. So --

A. Two pathologists.

Q. Okay. When you say at the present time, how long is that?

A. Well, before we had three and when I first got here there were more but we have restructured.

Q. Okay. So currently there is yourself and one other?

A. One other colleague who is a partner.

Q. When you say partner are you part of a group?

A. We're part of a corporation.

Q. And the name of your corporation'?

A. Is Pathmark, Incorporated.

Q. I'm sorry?

A. P A T H M A R K, Pathmark, Xnc.

Q. Okay. And how long --

A. And that's one word.

Q. Pathmark, okay.

A. All right.

Q. How long has that corporation been in existence?

A. I think since '79.

Q. All right. And I take it the corporation has a

contract with Huron Road to provide pathology services?

A. It is not a written contract at the present time.

Q. All right. But at one time it was?

A. Well, for a short period of time it's always been implicit.

Q. Just oral?

A. Oral.

Q. And you are, I take it you are a shareholder of Pathmark?

A. Yes.

Q. And are you also the president, CEO?

A. I'm the president. Well, I'm the president.

Q. And an employee?

A. An employee.

Q. Are you also an employee of Huron Road?

A. No.

Q. Okay.

A. And it's not Huron Road.

Q. It's Meridia Huron?

A. Correct.

Q. Okay. Used to be Huron Road?

A. It formerly.

Q. I'm sorry, I'm still in the old habit.

A. That's okay. We find some of our **loyal** friends in the same situation, if you would.
Q. It indicates that you're an assistant clinical professor at Case Western?
A. Correct.
Q. And how often do you teach at Case Western?
A. They have committees, and I have been on the, I think infection committee now for the last three, four years, and it's over a period I think generally six weeks and generally around six sessions, four to six sessions where you yo into small groups and --
Q. Well, I don't understand. I mean do you teach students at Case Western?
A. Correct.
Q. Okay.
A. And medical students.
Q. All right.
A. And there are small groups of students and you are assigned to them and they have assignments in terms of looking at slides and reviewing them and you answer questions and you also go over photomicrographs with them.
Q. Okay. And this would be **from** September through July?

through the middle of March or somewhere around

Q. So that's about a month and a half then?
A. Yes. It's a month and a half but it's only a number of sessions, a small number of sessions.
Q. Four to six I think you said?
A. Four to six and they're two hour sessions, generally, somewhere in that area.
Q. And how many students would be involved?
A. Well, we have --
Q. In any one *session?*
A. 20 or 30 in your little area, sometimes more, sometimes less.
Q. And would these students come back for all six

A. No. The students stay the same. Generally the people who assist may not make a session or two but usually we're there with the same students.
Q. Okay. And your function is to do what with

the microscope and also to review slides that

relate to the topics that they're currently studying.

Q. All right. Let me see if I understand. These would be medical students?

A. Correct.

Q. Would they be any particular year of study?

A. The freshman year.

Q. Freshman year?

A. At this point. I have been on any number of committees but Lately I have been on the freshman.

Q. So they're just being exposed to medicine their first year?

A. They are not jaded, right.

Q. And your function for these four to six sessions, is what, to give them just an introduction to pathology?

A. Let me give you an example.

Q. Okay.

pneumonia, and they will look at photomicrographs and I will ask them questions generally about what they see, trying to elicit the pertinent features of pneumonia, and then during the course of the session they'll put

slides under their microscope very similar to what or identical, what they have seen on the photomicrographs, and they'll then try and make observations and then raise their hand and ask you such and such is the case. We'll then discuss those features.

Q. Okay. Is this something that they're learning in the classroom and then you then come in and more or less --

A. They have a lecture generally that is relating --

Q. Okay.

A. -- to the pneumonia and then they will have a sort of a hands-on.

Q. I see.

A. Sort of workshop.

Q. So you provide the hands-on workshop?

A. That's correct.

Q. Okay. Any other duties related to your teaching at Case Western or is that basically it?

A. That's basically it. I think I served once as the volunteer person for their promotions but that was a one time only. It really doesn't relate.

Q. When you say promotions --

there, I couldn't figure that out but I did

Q. Why did you leave Kansas?

A. Well, there was this irresistible job in Cleveland and also the job in Kansas was -- I didn't think lead anywhere so those two things, the opportunity here in Cleveland and the fact that the job in Kansas was not as far as I was concerned providing the opportunities that I had anticipated.

Q. Okay. Is there any agreement or understanding amongst the pathologists in the Cleveland Society of Pathologists whereby if one of them is sued or in trouble he can look to other members of that organization for assistance?

A. No.

Q. How is it that you got involved in this case?

A. Dr. Mendelsohn called me and --

Q. Who is he?

A. Dr. Mendelsohn I think is chief at Mt. Sinai Hospital at the present time, and indicated that would I look at some material relating to this

issue, and I said yes, I would.
Q. How is it that you know Dr. Mendelsohn?
A. We're colleagues, and he is currently on the Board of Governors, I think, of the CSP, and I have known him from -- he was at University Hospitals, and he's got a very fine reputation in the community. I have sent him some material on occasion, so we have established I think a relationship of respect with one another.
Q. Okay. When you say chief at Mt. Sinai, chief of what?
A. Pathology.
Q. I see.
A. I am not sure of his exact title but I believe that he is the --
Q. What is his relationship with Dr. Siegler? Do you know?
A. Well, I think currently Dr. Siegler works in that department.
Q. Well, are they part of the same corporation that provides services there or do you know?
A. I don't know that. I do not know that.
Q. Doctor, is the last publication that you had 1985?
A. Correct.

Q. So this is a current CV?
A. This is a current CV.
Q. And the one before that had been 1979?
A. Correct.
Q. Do you have any publications as it relates to Pap smears or the reading of Pap smears?
A. I was thinking did I do anything in Pap smears, I don't believe I did or any cytologic, if you would, paper.
Q. And then the last abstract would be 1968?
A. Correct.
Q. Did you have any discussions, doctor, with Dr. Siegler in this case?
A. When we happened to see each other at the J, we briefly discussed this, and he said that he was aware that I was looking at the material. Very brief.
Q. When was that?
A. I don't really remember but it was after I had looked at the material.
Q. All right. Was it before your report?
MR. GROEDEL: What is the date of the report?
MR. BONEZZI: February 5th.
A. I think it was. I think it was. I am not sure

of that, okay, but I think it was.
Q. Okay. You had looked at the slides on January 17th, and you wrote your report February 5th, sometime in between those two dates?
A. I would suspect so.
Q. All right. And tell me what the discussion was that took place?
A. Did I look at the material and I said yes, and what did I think, and I just told him I thought it was, you know, I don't remember the exact words, but that it was perhaps something that wasn't too grave an error, somewhere along that line.
Q. When you say not too grave an error, meaning just a small error?
MR. BONEZZI: Objection,
MR. GROEDEL: I will object. Go ahead.
A. That I think the general thing is that these interpretations are difficult and that there's a wide range, if you would, of ways of interpreting Pap smears.
Q. Okay. You didn't have a tough time interpreting them, did you, doctor? You said that --
A. I think I looked at that with great care and in

terms of my interpretation, I think it's somewhat biased in view of the circumstances, so that my charge was to really make sure that something was there, and I looked at it carefully from that regard, and after some time I decided that there was something there.

Q. Yes. And I think you put mild dysplasia, correct?

A. Correct.

Q. And I assume that you view all the slides that are submitted to you for purposes of analysis with great care, because obviously a Lot depends upon how you read them?

A. That is correct.

Q. All right. And you would expect that would be true of all pathologists, would you not, or it should be true?

A. Yes. Mr. Kampinski, that is correct. I think that when we're particularly alert, if you would, there are some slides that you would look at a little more carefully than others.

Q. All right. Well, let me try to focus in on that because this is an important point. And if, in fact, you are asked to look at slides on someone that you know has had an abnormal reading

before, that would be one of the circumstances?
A. Correct.
Q. That would cause you to look at that slide even closer than you might normally?
A. I would have no difficulty agreeing with that.

I assume you have one. I will ask that in a minute.
A. Correct.

MR. GROEDEL: Technologist.

MR. BONEZZI: Technologist.

Q. I'm sorry, cytotechnologist reads a slide as abnormal and brings it to your attention, once again I assume under those circumstances, under that circumstance there would be a heightened awareness on your part?
A. That is quite correct.
Q. And you'd look at those slides?
A. Right.
Q. Much more carefully?
A. Right. And I would say that after looking at them very carefully and I came to the conclusion that I disagreed with the cytotechnologist, I would render my own opinion.
Q. All right. Here, of course, you didn't disagree

with the cytotechnologist who looked at them?

A. I didn't know what her diagnosis was prior to that.

A. Now I'm aware that she considered this a mild dysplasia.

Q. And you agree with it?

MR. GROEDEL: Objection. Go ahead.

A. I have so reported that I agree with that. I have no reason to change my mind at this point.

Q. And as a matter of fact, you have indicated that it might even be interpreted as moderate dysplasia?

A. I indicated that there was a range, and the range was, I thought on the low side but that it certainly could have gone up to moderate dysplasia, and on the other hand it could have gone down to atypia without mentioned dysplasia.

Q. If, in fact, there's a question in your mind about an interpretation, that is, atypia versus mild or moderate dysplasia, would you opt for the more serious diagnosis for purposes of affording the patient the greatest opportunity for the benefit of any potential interpretation

error?

MR. GROEDEL: Objection. Go ahead.

A. I think I will answer that by saying that I would, if I'm very comfortable with an atypical reading, rather than a dysplastic reading, you would err on really if you would causing great anxiety to a variety of people unnecessarily, if you're comfortable with that.

On the other hand, if there was some element of doubt I would concur with your diagnosis. I think that it would probably be preferable to go with your -- if you're iffy about it you would probably go with your more premalignant diagnosis.

Q. All right. You have got some depositions in front of you?

A. Right.

Q. Have you read those since the time of your --

A. I have read brief sketches of them and not a lot but --

Q. Have you read them since you have looked at the slides or did you read depositions before you looked at the slides?

A. No, I did not have any depositions before I

MR. GROEDEL: (Indicating).

Q. What material have you looked at either before or since looking at the slides, doctor?

A. Briefly went over some of Dr. Siegler's --

Q. Which one, both of them?

A. I don't remember that.

Q. Is this your entire file?

A. Yes.

Q. In front of you. Why don't you just let me take a look if you would, please. What you have got in front of you is a November 15th, 1990 Jeposition of Dr. Siegler, a deposition of Dr. Bonnell, and the February 11th deposition of Dr. Siegler, a copy of the August 1987 Mt. Sinai report, the April copy of the April '87 Mt. Sinai report.

MR. GROEDEL: It's Southgate, Chuck.

MR. KAMPINSKI: I'm sorry, Southgate report.

Q. Couple letters -- well, Dr. Bonnell's letter, a transmittal letter apparently from ME. Groedel to yourself, and your report, other letter from Mr. Groedel. Another letter from Mr. Groedel,

another one, the photomicrographs that you took, and there's nine of them here.

Are those all of the ones that you took?

A. I believe so.

it but I -- it's something that I did some time ago.

Q. Okay. And then an article by Leopold Koss and by John Seybolt and William Johnson.

Did you do research that resulted in these articles being in your file?

A. Since I was called on to look at this material I thought I would at least do some review, and this is -- I had Koss' article in my, in my file and I read it and then I think I got that other article via Koss.

Q. It's referenced in Koss?

A. I think so. I think so.
Q. All right.
MR. KAMPINSKI: And you'll provide us with copies of this.
MR. GROEDEL: Sure.
MR. KAMPINSKI: Great.
Q. In reviewing Dr. Siegler's deposition, I assume you agree with him wherein he indicated that if, in fact, you have a negative, I'm sorry, if you have a positive result on one test, that is, an abnormal finding, and then you have a negative test thereafter, that you ignore the negative is test and you go with the worse finding?
MR. GROEDEL: Objection.
Q. Do you recall that testimony?
A. No, I don't recall that testimony but if you want me to respond --
Q. Yes, please. Would you agree with that?
A. You know, if you have a positive result of dysplasia and you do another test very shortly thereafter, you are likely to have a negative result in a fairly substantial number of cases I think if you do it within a reasonably short period of time.
Q. Short period of time being three months?

A. Weeks. No. I think three months there's a much better correlation. For one reason or another. I would say that if you subsequently have a negative result after a positive result I don't think it would erase the positive result, necessarily.

Q. Meaning that -- well, what is the meaning of that for purposes of both a pathology --

A. Meaning that perhaps the patient --

MR. GROEDEL: Objection. Go ahead.

A. Meaning that that patient may still be subject to more intense scrutiny than necessarily you would do if there were no positive result.

Q. All right. Are you talking now from the clinician's standpoint or the pathologist's or both?

MR. DAPORE: Objection.

A. I'm talking from the pathologist's standpoint but using my, putting myself I guess in the position of what is good for the patient.

Q. All right. Let me try to put that in specifics, doctor.

A. Go ahead.

Q. If you have a reading of dysplasia, three months

later followed by a reading of cell study negative, okay, atypical cervical cells are patient?

MR. GROEDEL: Objection. Are you going to grade the degree of dysplasia or not?

MR. KAMPINSKI: Well, I don't care.

Q. Let's say mild cervical dysplasia originally in April of 1987 followed by -- and by the way, let me stop, I mean whether you say mild, moderate or severe, dysplasia has to be followed, doesn't it? If you find dysplastic cells, those have to be followed, do they not?

A. Let's -- let me ask you *to* rephrase that question, okay, because it's a very loose question.

Q. Well, I mean if you as a pathologist have a finding of dysplasia --

A. Correct.

Q. -- regardless of the degree --

A. Right.

Q. -- that is something that you would recommend

follow-up, correct?
A. You could either recommend, if you have some understanding with your attending physicians or you don't need to recommend.
Q. Okay.
A. If you're attending physician understands what he should do, he is looking at the patient and doing all the other things that in addition to taking the material. But this test by virtue of itself usually would demand some action.
Q. Okay. And according to Dr. Siegler's standard it requires a repeat Pap within three months, a finding of mild cervical dysplasia?
A. Okay.
Q. You don't disagree with that, do you?
A. I would not disagree with that. I think that there would be a variety of ways to manage that, but that would be in the purview of the attending physician.
Q. Okay. But that would be appropriate follow-up recommendation for a pathologist?
A. I would -- I would not disagree with that.
Q. Okay. If that is then followed by a finding of neoplastic study or neoplastic exam, cell study negative with a note indicating atypical

cervical cells are present, what is the appropriate standard of care in terms of follow-up on that patient at that point in time having -- given the fact that in April of '87 mild cervical dysplasia was found?

MR. DAPORE: Objection.

MR. GROEDEL: Objection.

MR. DAPORE: From the standpoint of a pathologist or --

MR. KAMPINSKI: Both.

MR. DAPORE: Objection.

A. I think that it would be an area that, again, would be a little bit out of my realm of expertise, but generally I would, not to evade the question, I would think that a higher degree of scrutiny would still be demanded.

Q. All right. What does that mean in terms of timing, though, doctor? Are we talking about immediate punch biopsy, are we talking about Pap in another three months? I mean what --

A. See, these are areas, again, that are not areas that I -- we determine the degree of abnormality. The clinical doctor who sees the patient and takes care of the patient would determine what should be done, but I would say

that in my opinion that it would be something other than just following that patient in that routine. I still think she would be in a higher risk category.

Q. Do you have recommendation standards that you

A.

Q.

A.

Q.

A.

Q.

A.

at generally, I can't say for sure but a good number of gynecologists who mainly do not find

our recommendations to their looking.

Q. Okay. What about, do you differentiate then between who sends you the slides?

A. We don't. We just have not come, you know, we

Q. Such as?

A. I don't know, maybe three to six months. I

Q. I take it based on what you're saying then you as a pathologist given these two reports would have anticipated that the clinician, whoever he might be, whether he be family practitioner, gynecologist, would have done something in the near future to further follow-up on this lady's condition?

MR. DAPORE: Objection.

MR. GROEDEL: Objection. You can answer.

I would say that if that -- I think that would have been appropriate to perhaps, not with the exact follow-up intervals or what to do is something that I would not want to even speculate on, but I think some increased, if you would say, scrutiny for this particular patient.

Q. Well, wouldn't it concern you, though, doctor, that the clinician receiving a report that says cell study negative, might be falsely reassured by such a finding?

MR. GROEDEL: Just cell study negative?

Q. Well, and atypical cervical cells are present.

A. I think that the report probably would reflect that some atypia is present.

Q. That's what you read atypical cervical cells are present to equate to that is atypia?
A, Atypical, yes, atypical cervical cells are present. I would think that is, you know, is a small abnormality, a minor abnormality and as such is an abnormality in view of the other diagnosis.
Q. You mean the earlier Pap?
A. The earlier Pap might have probably would have been appropriate to put this patient in a slightly higher scrutiny category, for whatever you would do for that.
Q. With regard to the cytotechnologists that work

Q. All right. And I'm sure you had some input in their training and have taught them what to look for?
A. There's an interaction. There's a constant interaction if you would. It's something that we impart part to them and they're on their own. It's a day-to-day given sort of give and take. They teach us as well.

Q. Okay. Do they employ a technique whereby they circle suspicious areas for you to scrutinize if, in fact, they see something suspicious on the slide?

A. Correct.

Q. And the reason they do that is what, doctor?

A. So that I think it's, you know, sometimes it's very hard to go back and locate the abnormality that you have under there right now so that it really then means they can go back and then impart that field to the consultant.

Q. I see.

A. And we do that not infrequently on anatomic specimens, too, or tissue specimens so that we can call attention to certain areas.

Q. So that would be incumbent upon them within their standard of care to bring to your attention those areas of abnormalities that they saw, correct?

A. That's their job.

Q. All right. And I assume the other part of that is that when you as a pathologist are provided with those slides that they bring to your attention as showing some abnormalities, probably focus on the areas that are circled?

Would that be a fair statement?
A. That's correct.
Q. Okay. The slides that you looked at on January 17th had areas that were circled, did they not?
A. Correct.
Q. All right. Your finding of mild dysplasia was that, was your opinion that the circled areas contain mild dysplasia or that areas other than the circled areas contain dysplasia?
A. Well, you know, I didn't ask myself that question at the time. I think most of the photos that I took were within the circled areas, and I suspect most of the -- I think that my, whether I -- whether I looked at other areas or not, I undoubtedly must have looked at other areas. Whether they influenced me in my decision to call this a mild dysplasia or not, I really can't say at this point.
Q. Because you just don't remember?
A. I don't remember.
Q. All right. That's not something you focused on?
A. No, it really isn't.
Q. Let me give you at least a hypothetical, doctor, which may or may not be accurate depending upon your looking at these slides. Again, just

assume for the sake of answering these next few questions that the areas that were circled on the August of '87 slides contained what might be classified as atypia?

A. Okay.

Q. And that other areas on the slide contained dysplasia?

A. Okay.

Q. Including, perhaps even severe dysplasia?

A. Okay,

Q. And that for whatever reason those were not seen by Dr. Siegier?

A. Okay.

Q. Either he didn't look at them because he was to focused on the circled areas or he just didn't see them?

A. Sure.

Q. For whatever reason. Would that have been a failure then on the part of the cytotechnologist to have brought those other areas to his attention on those slides, in your opinion?

A. The question that you raise is as to the observation being missed, if observations like this are missed consistently by the cytotechnologists, and you are in a position to

be aware of that, 1 think that it certainly would behoove you to get another cytotechnologist.

Q. Please. I don't want the question to be misunderstood.

A. Then phrase it again.

Q. Okay. I am not asking you to judge the competence *of* somebody over a period of time, we're talking about particular slides of a particular person on a particular day.

And the question I have is if, in fact, that person did not identify areas of mild, moderate or severe dysplasia on those slides but rather circled areas of atypia, would that have been a failure of that person to do their job appropriately on that day, on those slides?

abnormal. However, let's just put it where it's at, it's not infrequent that the

and you as a pathologist are going to find those from time to time.

Q. Oh, sure. I mean I assume we have no disagreement, that is still the obligation of

the pathologist when he looks at those slides to review the whole slide?

A. Well, he'll generally not spend an enormous amount of time looking at every field, but if he is so inclined, if he becomes suspect for some reason or another, he would look at it carefully.

Q. If you become aware of a previous Pap smear having been read as abnormal, containing dysplastic cells, and you are now doing a repeat --

A. Right.

the other material, I think that would have been desirable if it would have been convenient, and if I had access to it, but I think that it's not uncommon for us to not review previous material

depending upon what we see on the present material.

Q. Doctor, were you given, and I apologize because I didn't see it, maybe you were, but were you given the laboratory request to look at with respect to the August 22nd, 1987 --

A. That's in one of tnese things.

Q. So you have seen that?

A. I have seen that.

Q. All right. And you can look at this if you want.

A. Go ahead.

Q. Because I have got a couple questions. I mean it says Eollow-up abnormal Pap, does it not?

A. Yes, correct.

Q. Okay. So this alerts you as a pathologist that

Q. Sure. And once again, under those circumstances, would you want to see the previous abnormal Pap if, in fact, it was accessible?

MR. GROEDEL: Objection. Go ahead.

A. It would be desirable, but it would not be uncommon in the press of your daily activities to not make a big effort to do this.

A. Let me rephrase my answer, okay'?
Q. Go ahead.
A. That it would not be uncommon for you not *to* do this.
Q. Doctor, correct me if I'm wrong, but what you do can have very serious impact on somebody's life?
A. Correct.
Q. And I assume you cake what you do very seriously?
A. I do.
Q. And following up an abnormal Pap can mean life or death for a patient?
A. It is -- it's a matter of certainly importance, but I think the more important information to convey to the clinical doctor is what you are seeing on the present material. **I** mean he is aware, **I** would assume, of what is on the previous material, and what you see on the present material is of far greater importance than reviewing the previous Pap.

Q. Well, is it important to let him know that perhaps there is an observer who you trust and who has worked for you for 20 years who reads it as containing dysplasia whereas you might read it as negative cell study, atypical cells present?

A. Well, Mr. Kampinski, I think that as the pathologist you are weighing what you put down on your report with a great deal of care, and your experience, I would assume is the expert, as the captain of the ship, and you make a decision, and you are comfortable with it and I think that that's all I can say.

Q. He was wrong, wasn't he?

MR. GROEDEL: Objection.

A. I would answer to that by saying I can't really say that.

Q. Well, did you say it in your report?

A. No, I did not. And I think you are putting --

Q. Well, you read it as dysplastic, I mean the cytotechnologist read it as dysplastic, Dr. Bonnell read it as dysplastic?

A. That doesn't mean that he's wrong and I'm right, it means that his interpretation there was different than mine, okay. Now, indeed I think

I would leave it at that.

Q. Well, see, I can't leave it at that. How do you distinguish between atypia and dysplasia,

the amount of cytoplasm.

Q. In other words, the larger the nucleus, the less cytoplasm, the more abnormal and the more likely it is dysplastic as opposed to atypical?

A. I would agree with that.

Q. And if you see sheets of cells like that that would be what?

A. Well, I think sheets are my opinion only important if they reveal the cytologic detail, and sometimes sheets are much more difficult to analyze because they're so coherent to one

another, and you can't really observe the nuclear detail that you can in single cells.

Q. Well, if that's true, then don't you have to report to the clinician and that perhaps the specimen is not adequate for you to make a determination?

A. i think you see sheets quite frequently on cells and you see single cells so I think it's a composite and I don't believe sheets necessarily mean that something is not adequate or is idequate.

). Well, if you nave sheets of abnormal cells what does that mean?

A. Well, I think that if you have sheets of abnormal cells they can be regenerative, they can be atypical, they can be dysplastic. I think you would evaluate them accordingly.

Q. Okay.

MR. KAMPINSKI: Can we plug this in?

Q. While he is doing that, doctor, you saw Dr. Siegler's testimony where he conceded that some of the cells that he saw were, in fact, dysplastic?

MR. GROEDEL: Objection. *Go* ahead.

Q. Did you not?
A. I don't remember reading that per se.
Q. You don't?
A. No, but if you say it's there I will accept that.
Q. So that even he acknowledges that he didn't see the dysplasia that was present on these cells?
MR. GROEDEL: Objection. I mean

Do you know?
MR. GROEDEL: Objection. If you know.
Q. I mean did you ask for them?
A. No, I did not request them.

Q. Okay. Doctor, I'm going to put on the screen what have been marked at Dr. Siegler's deposition as Exhibits 4 and 5.

A. Okay.

Q. Okay. And these are photomicrographs of the August 1987 slides.

A. That was the one that was from his laboratory in Southgate.

Q. Yes, sir.

No,

MR. GROEDEL: Second one.

MR. KAMPINSKI: From Mt. Sinai?

MR. CROEDEL: The one in question.

MR. KAMPINSKI: Right. With any luck this will work.

What number was that one, Chris?

MR. MELLINO: What were the numbers?

MR. KAMPINSKI: 4 and 5.

MR. MELLINO: That's 4.

Q. The one you are looking at right now, doctor, was marked as Exhibit 4 of Dr. Siegler's deposition. Can you tell me what we're looking at, sir?

A. It's a cluster of squamous epithelial cells.

Q. Are those normal?
A. It's not a very good reproduction. Can you focus it or is that the best you can do?
Q. You want to get closer?
A. That's not going to help. It's fuzzy.
Q. You can't tell anything from that, doctor?
A. I would not hazard an opinion on that. It's not a good reproduction.
Q. Do you recall seeing that cluster of cells on the slides that you looked at?
A. I certainly recall something similar to that. I don't know if it was the exact specimen.
Q. And are those what you referred to as mild dysplasia?

MR. GROEDEL: Objection. Go ahead.

A. I don't remember the exact, you know, cells that I fixated on for mild dysplasia but those cells are not, as I recall even in the preparation, they're not particularly well preserved in this study and probably they could be easily misinterpreted for a higher grade.
Q. For a higher grade meaning what?
A. Of --
Q. Severe dysplasia?

A. They could be probably, if you interpret material like this which is not well prepared I think you are liable to overcall it.

Q. Well, I mean apparently this wasn't called at all?

MR. GROEDEL: Objection.

A. Well, go ahead. You want me to answer that?

Q. Please.

MR. GROEDEL: Yes.

A. Are you making that statement?

Q. Yes. I mean that's accurate, isn't it?

A. I don't believe so but I don't know how you know that.

Q. Well, because I think it says in the August of '87 report that there's no cell abnormalities?

MR. GROEDEL: Objection.

Q. Or cell study negative, right?

MR. GROEDEL: Objection.

Q. Isn't that what it says?

MR. GROEDEL: Well, it says more than that. I mean you're splitting the report up.

MR. KAMPINSKI: I'm not. Dr. Siegler did.

MR. GROEDEL: Well --

A. Do you want me to respond to that?
Q. Please, if you would.
A. This perhaps could be atypical cervical cells, you know, I think it's within that realm. They're not, again, well preserved material.
Q. Wait. Let me make sure I understand. You are saying that this could be atypical cells, doctor?
A. It perhaps could have been interpreted that way.
Q. Do the nuclei look --
A. I maintain that the nuclei are not well preserved and theretore it's difficult to really base an opinion on that material, particularly as we see it here.
Q. All right. Why don't you put on 5, please. Looking now at what had been marked as Exhibit 5 at Dr. Siegler's deposition.
A. Those are fuzzy, very fuzzy --
Q. We'll try to focus it a little bit. We'll see if we can't get you some real good blowups for trial, doctor.
A. Mr. Kampinski --

MR. GROEDEL: It wasn't a question. It's okay. You don't have to respond.

Q. I mean we don't want you to have any difficulty with this. How's that for focus, sir?
A. That's better.
Q. Okay. Now, what do you see on Exhibit 5, doctor?
A. Similarly there are clusters of squamous epithelial cells, and I think that reading them off the screen I think they're abnormal and in the low range, mild dysplasia, atypical.
Q. Well, if I look at these cells, what is it that would distinquish the, quote, "mild atypical" from dysplasia?
A. I think you would need better definition of those cells to really resolve that. I think the cluster here is not well preserved, and is not a particularly good cluster to base your diagnosis on.
Q. Well, if you were concerned as you were with the last one, that they could be overcalled as severe dysplasia, I think that's what you said?
A. Perhaps.
Q. On Exhibit 4, once again, would you --
A. I think that thought would go through your mind.
Q. Okay.
A. And you would try to resolve the cells but as

you look at them you don't see a good, definite nuclear pattern here.

Q. Well, my point, though, doctor, is if that was a concern of yours, and looking at those cells as an expert pathologist, would you not then tell the clinician that the specimen you had was not well preserved and you would want, you know, an additional specimen or a better, you know, better swab?

A. Are you finished?

Q. Please. Go ahead.

A. I think you would do a better overall evaluation. And if you see a small amount of

small areas that are not easily, if you would, interpreted.

Q. All right. But the interpretation here would range from your saying atypia to what grade of dysplasia?

A. Mild dysplasia.

Q. Mild?

A. Yes, mild.

Q. Not moderate?
A. It would -- I think I would go on and look at the rest of the material.
Q. Well, looking at this, how about severe?
A. No. I think it would be very unlikely.
Q. How do we tell the difference between moderate and severe?
A. Well, you would certainly see much more nuclear change in a severe dysplasia.
Q. Such as?
A. Such as much more hyperchromaticity and probably less cytoplasm.
Q. In other words, bigger nuclei?
A. Probably irregular nuclei. The contour would be helpful in that regard.
Q. Well, what kind of contour would you be looking at?
A. Well, you'd be looking for irregularities.
Q. Such as?
A. Wavy, bumpy.
Q. As opposed to smooth ones?
A. Smooth.
Q. Well, could you point out to me the smooth ones you see. Maybe we can approach this and maybe you can show me what you are talking about.

A. Well, I think, a

sir?

A. I think that's a high drive.

Q. I'm sorry?

A. High drive.

Q. I still can't hear you.

A'. High drive. Wouldn't that be somewhere around 10 times 40, 400? Is that correct?

MR. KAMPINSKI: I think it's got it on there, Chris.

Q. Dr. Siegler described both of these as dysplastic. Would you disagree with that?

MR. GROEDEL: Objection. Go ahead.

A. Well, I certainly think that that's reasonable.

Q. Well, could you tell me whether or not it would, in fact, have been appropriate for him to have advised the clinician that these cells were dysplastic in 1987?

A. If --

THE WITNESS: Do you want to object to that?

A. If he indeed made that determination he should have reported it.

Q. Well, but I mean that's his job is to make that determination if it's on the slide, isn't it?

A. If he had made that determination he should have reported it.

Q. No. You are not listening to my question.

A. Okay. Rephrase it.

Q. If it's on a slide that's his job to find it and to report it?

MR. GROEDEL: Objection. Go ahead.

Q. Isn't it, doctor?
A. If indeed the facts are such that he can render that judgment, it's his job to do it.
Q. Look, I don't want to mince words with you, doctor, because I mean you are being very careful in your wording of these responses. My point is it's his job to find the abnormalities?
A. No question about it.
Q. All sight. And if they're there and he doesn't find them he hasn't done his job?
MR. GROEDEL: Objection.
Q. Isn't that fair?
MR. GROEDEL: Objection. Go ahead.
A. I think they are -- I don't have any objection -- I can't take objection to what you're saying, Mr. Kampinski. I can say that there's varying interpretations to material.
Q. Well, and if he interprets it wrong he hasn't done his job either?
MR. GROEDEL: Objection.
A. We, again, don't know exactly what wrong is.
Q. Wrong is normal when it's abnormal.
MR. GROEDEL: Objection. Go ahead.

A. Indeed if he interprets something as normal when it's abnormal, it would speak for itself.

Q. Doctor, I have put another slide up. Can you comment on what you see there?

MR. GROEDEL: Can you identify what you're showing?

MR. KAMPINSKI: Yes. I think those are also from the '87 slide.

MR. GROEDEL: Which one?

MR. KAMPINSKI: I think those are August as well, sir.

A. It's a cluster of squamous epithelial cells that shows a similar abnormality.

Q. When you say similar abnormality, I have got to ask you to be a little bit more specific.

A. I think it shows an abnormality that is probably in the range of -- first of all, let me say that it's not a good preparation for the same reasons that I said the other one is not a good preparation. And as such it shows a similar set of circumstances where we see cells that are generally large, not well-defined, generally round, and can be interpreted as a mild dysplasia.

Q. Okay. Doctor, I'm going to ask you or I'm going

to put on the slides that you did?

A. Sure.

Q. And I'm going to ask you to comment on those.

MR. KAMPINSKI: Why don't you take that one out, Chris, and put his in. And before you put them on there, why don't we mark them as -- let's have Aneta mark the back of them as Rabin -- am I pronouncing your name right? I apologize.

A. You are not pronouncing it right, Rabin.

Q. Rabin 1, 2, 3, 4, 5 --

- - - -

(Thereupon, Plaintiff's Exhibits 1

Q. Okay. And how did you determine what areas you were going to make photomicrographs of?

A. You know, at the time I thought I'd take what I thought was fairly representative stuff.

Q. Okay. And by looking at these are you going to be able to tell which smears these are

photomicrographs of?

A. I only took photos of one smear or there are two smears. I don't know. I don't remember that.

Q. But that was the August of '87 ones?

A. it was the only one, right, that I was asked to comment on.

Q. Okay. Do you have, by the way, other labs than the one that you mentioned?

A. No.

Q. Okay. And do you do work for outside physicians?

A. Yes.

Q. So they send them in and your lab does them here?

A. We pick them up. We have a little courier service.

Q. So it's not just people within the hospital?

A. It's generally doctors related to the hospital.

Q. Right. Who have privileges here?

A. Yes. Generally. I don't recall us doing the work. Too many -- although we do some podiatric work for other -- with nonpodiatric members of the staff, I suspect. So there are a few minor exceptions.

Q. The report, the August '87 report, doctor --

A. Yes.
Q. __ the fact that it says cell study negative --
A. Yes.
Q. __ and then later after Dr. Siegler's signature it says atypical cervical cells are present --
A. Correct.
Q. -- are those inconsistent?
A. I wouldn't consider them inconsistent.
Q. Well, which is it, I mean are there atypical cervical cells present or is the cell study negative?
A. My comment is that it may not be a very desirable way to report, but I think if I were to view that report I would certainly look at the most abnormal part of it, namely the atypical cervical cells present.
Q. All right. Which is different than negative cell study?
A. It's confusing, the negative cell study and the atypical cervical cells present, but I would still -- the atypical cervical cells would certainly raise the antenna.
Q. Okay. I mean it is incumbent, is it not, on the pathologist not to be confusing?
A. We try our best not to be confusing.

Q. As a matter of fact --
A. We don't always succeed.
Q. Well, as a matter of fact, the atypia category has been done away with or at least the recommendation was to do away with it by the Bethesda study, correct?
MR. GROEDEL: Objection.
MR. RONEZZI: Objection.
A. There are a variety of ways to impart, and really the most important part of it *is* to try and report to the attending physician the degree of abnormality that you perceive, and there are varying deyrees of abnormality that are -- that you would not consider dysplasia, and how you report that, certainly atypical cervical cells I think would be quite appropriate.

MR. BONEZZI: Objection,

am not very familiar with it but there are a variety of other ways to do things other than that particular way of reporting.
Q. Well, you disagree with their findings?

MR. GROEDEL: Objection. Go ahead.

A. I don't know precisely what they are saying. I just know what you say they're saying and until I have looked at that carefully --

Q. Do you still use atypia in your reports?

A. We certainly could use atypia.

Q. I'm sorry, you do?

A. We certainly can, sure.

Q. Still today?

A. Still today. We would sometimes use atypia, not definite for dysplasia. It would be a very appropriate way of saying, hey, I'm a little concerned about something, but I don't think it's definitely dysplasia.

Q If you use atypia --

A. And I think that -- let me finish my thought there.

Q. Sure.

you're really concerned a little bit about it but you can establish the diagnosis of dysplasia.

Q. If you use atypia in a report do you further go on to define what you mean by atypia?

MR. BONEZZI: Objection.

A. No.

Q. You don't?

A. No. I think that we do not.

Q. All right. If you would show the slides. We have numbered these, doctor, 1 through 9. I'm assuming that we're starting with 1.

A. Right.

Q. And if you would just comment on each of them as --

A, Very similar to the material that you just went through.

Q. Right.

A. And I have the same surprise. I would focus in on something like that but that's very similar. Go ahead.

Q. Well, how do you --

A. I would think it would be in the realm of a mild dysplasia.

Q. Okay. That's No. 1. All right. What are we looking at here, doctor?

A. We're looking at some single cells with irregular nuclei, and, again, I think they could well be mildly dysplastic cells. Have a lot of cytoplasm, some inflammation. The two big cells

Q.

A.

Q.

A.

Q.

A. They have a lot of cytoplasm and they are not

Q. How about the size of the cells?

A. They are big.

Q. And what does that tell you?

A. That they could easily be making protein, if you would, in a regenerative phase or in a perhaps premalignant phase.

Q. And that is one of the reasons that Pap tests are done, is to identify premalignancies such as dysplasia?

A. Correct.

Q. And that's one of the great advances that have been made in medicine and pathology is the Pap test?

A. Certainly is beyond dispute as far as I'm concerned, yes.

Q. And if, in fact, you can identify dysplasia, and remove it prior to its progressing to cancer, you have, in essence, saved that person's life in all probability, have you not?

MR. BONEZZI: Objection.

A. That speaks for itself. I would agree with it.

Q. Okay. I'm sorry. Continue. This is No. 4. What is that?

A. That's a very low power, I can't really, don't even know why I --

MR. GROEDEL: Keep your voice up, doctor.

A. it's a very low power. Maybe some of these streams of cells. Are there higher ranges on those?

Q. Let's stop for a second. Up in the upper right-hand corner it looks like a circle. Am I incorrect about that?

A. I think you are.

Q. How about closer to the middle but still in the upper right. Is there a circle there?

A. I don't know. You mean in ink? Come on up and show me what you mean.

Q. Right. Mr. Dapore seems to know what I'm looking at.

A. Oh, no. Oh, no. No way.
Q. Why is it that you took this slide, doctor?
A. I must have thought it was typical of what I wanted to take. I don't know. It's just something that struck me at the time. Maybe there was --
Q. What is it about the slide that struck you?
A. But I can't be sure. Again, maybe if we could focus that a little better. I think there are little streams of -- there you go. Little streams of larger cells, if you will.
Q. And *by* larger cells, are you talking about the nuclei being more prominent?
A. Yes, perhaps. Yes.
Q. And does that indicate to you a dysplastic process?
A. Not necessarily. It's abnormal and you'd want to look at it higher.
Q. Higher magnification?
A. Yes.
Q. All right. But that would be something that you would see at a lower magnification that would alert you to the possibility of dysplasia?
A. Correct. Correct. Or abnormality.
Q. Okay. Fine.

MR. KAMPINSKI: Go ahead, Chris.
And this I think is No. --
MR. MELLINO: 4.
Q. 4. Now, is this a close-up of what we just looked at?
A. I think so. I think so. Best of my recollection. And the cells are fairly round, not hyperchromatic but enlarged with a lot of cytoplasm and you would wonder about atypical cells, not dysplastic, you would think of a mild dysplasia. I consider these mildly dysplastic.
Q. (Okay. Go ahead. This is No. 5. This, once again, is a small area under low magnification, correct?
A. I would say so for sure, yes.
Q. And why is it that you took those?
A. Maybe if we go up higher.
Q. Let me stop there. Is there something about the color or the enlarged --
A. Well, it would have to be this central area that caught my attention.
Q. And we can see even from that low magnification there are some fairly large cells in there?
A. A few, correct.
Q. All right.

MR. KAMPINSKI: *Go* ahead, Chris.

Q. Is this the higher magnification then of those cells you think?

A. Yes. I see -- no. I am not sure but maybe. No, I don't think so. Do you want to go back? I don't believe -- perhaps. It doesn't seem to represent what I'm looking at there. Go ahead. Anyway, they're similar or --

Q. We're now looking at No. 6?

A. Okay. Is that focusable better?

Q. 6?

A. Can that be focused any better'? Not well preserved cells at this point.

Q. so --

A. I wouldn't base it, any strong interpretation on a --

Q. All right. Then why did you take these? I mean were these representative of something you wanted to do?

A. Probably I took them because, you know, the just caught my eye at the time but as I look at them and reflect on them I can't really make a judgment on them.

Q. Okay.

MR. KAMPINSKI: *Go* ahead, Chris.

This is No. 7?

A. Yes. Again, I think the view, irregular, atypical single cells, that, again, still have a lot of cytoplasm, not too hyperchromatic but some irregularity of their nucleus and I think they're in keeping of mild dysplasia.

Q. And as they progress from mild to moderate to severe is what we would see then larger nuclei and less cytoplasm?

A. And more irregularity and much deeper stain of the nucleus.

Q. Okay. And wnen you say irregularity, irregularity in the nucleus, in the cell or both?

A. Irregularity in the nucleus, primarily.

Q. Okay.

MR. KAMPINSKI: Go ahead, please. And this I believe is No. 8? Am I right or --

MR. MELLINO: Yes.

A. A few irregular cells, again, not well preserved in that area, but, again, I think in keeping with a mild dysplasia.

Q. Okay. And then lastly, No. 9?

A. Some vacuolated cells.

Q. I'm sorry?

A. Vacuolated.
Q. Vacuolated?
A. Vacuolated cells.
Q. What are those?
A. Cells with empty appearing cytoplasm, if you would. Let's put it that way.
Q. The reason I'm asking you to repeat it, it's very hard for her *to* hear and write down. Empty appearing cytoplasm?
A. Areas that are devoid of stain.
Q. And what does that mean, doctor?
A. Not much I think. Again, you'd focus on the nucleus, the large nucleus and they are large nuclei.
Q. And those nuclei, doctor, almost take up the entire cell?
A. Yes. Again, I hasten to add this is not an area that is either well preserved or it doesn't come through on the photograph.
Q. Let's take it for what we do see.
A. I would say that probably there's a substantial amount of cytoplasm in those cells.
Q. Not that we can see, though?
A. Oh, yes. Probably, you know, the vacuole and the areas around them and this one over here

also has a fair amount of cytoplasm.
Q. I see. So you would still consider those mild or moderate?
A. I would put them in the low end of things, and, again --
Q. You've got to help me.
A. Low end, mild.
Q. Not moderate?
A. Not moderate.
Q. You are sure about that?
MR. GROEDEL: Objection. Asked and answered.
Q. I mean as you --
A. That is my interpretation.
Q. But I mean as you defined mild and moderate for me before, it seems like this one's getting to almost severe?
A. No.
Q. No?
A. No.
Q. How about moderate?
A. No.
MR. GROEDEL: Objection. Asked and answered.
Q. Still mild, right?

A. I think it's in keeping with mild.
Q. Okay. But certainly dysplastic?
A. I think that it's in keeping with that. There are some areas that are better that perhaps, you know, you take everything in context and the overall interpretation I think is well within keeping with mild dysplasia.
Q. All right. Now, these nine photomicrographs, doctor, you took them from different areas of the slide, it's not all the same area?
A. Correct.
Q. So there's mild dysplasia all over this slide?
A. There are cells that have this abnormality that are certainly interpretable as mild dysplasia and they're not just a few.
Q. Okay.
MR. ICAMPINSKI: Why don't you turn that off and put these back.
Q. Doctor, do you have any opinion as to whether or not had the August 1987 report been read as dysplastic -- mild dysplasia, with a recommendation for either repeat biopsy in three months or I'm sorry, what was the other procedure you indicated?
A. Colposcopy.

Q. Colposcopy, as to whether or not Sherleen Wynn would be alive and well today?

MR. GROEDEL: Objection.

Q. Do you have an opinion?

MR. GROEDEL: Objection.

A. That's a very important question.

Q. Yes, it is.

A. And I think that it's one that is speculation but I think that in fairness that if indeed something were turned up and appropriate management taken that I have no question that this can be a life-saving procedure, namely either removal of the uterus at an early stage if indeed this was the case at that point.

Q. So your opinion is that had it been read as dysplastic cells and the appropriate follow-up done she probably would have --

A. I am not sure that --

MR. GROEDEL: Let him finish the question.

MR. BONEZZI: Objection.

MR. GROEDEL: Objection. You're assuming that that's what was present at that time, then?

MR. **KAMPINSKI:** Absolutely, yes,

A. Just rephrase it and I will let you finish.

Q. Sure.

A. **I** will try not to interrupt you.

Q. That's fine, doctor. **I** don't want there to be any misunderstanding, confusion with respect to semantics.

If, in fact, the August 1987 slides had been read as containing dysplastic cells, and that follow-up had then occurred by either repeat biopsy and/or colposcopy with additional follow-up thereafter, based upon what we now know ultimately progressed to be cervical cancer, based on what you have just said, I assume it's your opinion had that been done at that time she would have been cured and probably a1ive.

MR. GROEDEL: Objection.

MR. BONEZZI: Objection.

A. Okay. **I'll** try and answer that question.

Q. Okay.

A. **I** think that if a lesion had been detected though a variety of means, and that lesion was in the precancerous or early cancerous phase, appropriate management instituted, that this can

be life-saving, so be it.

Q. Well, when you say can, I mean there are distinctions in -- legal distinctions in the terminology we use and I said probably because it has legal connotations. Probably is defined as 50 percent or more. Would she probably have been cured and saved?

MR. BONEZZI: Objection.

MR. GROEDEL: Objection. Go ahead.

Q. In your opinion?

A. If the first part of the premise is that something had been detected --

Q. Yes, sir.

A. -- is valid, then the second part of the premise I would say probably she could have been cured.

Q. Okay. And in retrospect as we look at it now obviously with 20/20 hindsight --

A. Right.

Q. -- she died of cervical cancer, in terms of the first part of the premise we can assume that had an appropriate workup been done at that time that the lesion would have been found?

MR. BONEZZI: Objection.

MR. GROEDEL: Objection.

Q. Can we not, doctor?

MR. **BONEZZI**: Objection.

Q. Probably?

MR. **BONEZZI**: Objection.

A. I think that **I** can't find any great -- now in that line of argument.

Q. Okay.

MR. KAMPINSKI: That's all I have. Some of the attorneys might **have** some questions. I'm done.

MR. BONEZZI: Doctor, even though I have the right to ask you questions I choose not to exercise that right at this time.

MR. KAMPINSKI: And I disagree. Since you are not going to ask questions who cares.

MR. DAPORE: I have no questions.

MS. SFISCKO: I have a few questions.

MR. GROEDEL: Almost made it out of here.

MR. KAMPINSKI: I don't want to confuse before we get started your stuff with mine. I think this is all yours.

This is a CV we can hang on to.

THE WITNESS: I would say that that's --

MR. KAMPINSKI: And you'll provide us with copies of the --

MR. GROEDEL: Of the articles.

MR. KAMPINSKI: The reports.

MR. GROEDEL: Right.

MR. KAMPINSKI: I'm sorry, Joan.

- - - -

CROSS-EXAMINATION OF ERWIN R. RABIN, M.D.

BY MS. SFISCKO:

Q. Doctor, I represent the Mt. Sinai Medical Center.

A. Sure.

Q. Do you have any opinions or any opinion regarding the standard of practice of the cytotechnologist Virginia Frageris?

MR. KAMPINSKI: I'm going to object because he's already testified as to some of those.

MS. SFISCKO: I wasn't clear.

A. Rephrase that question to me.

Q. Do you have any opinion or opinions regarding the standard of practice of the cytotechnologist

Virginia Frageris?

A, No.

Q. You don't have any opinion regarding her standard of practice?

A. You know, I think she worked at our hospital for a brief period of time, and my recollection is that she was an expert cytotechnologist, but that's referring back maybe some years.

Q. Okay. Is it a standard of practice for the pathologists to look beyond the circles that a technologist would make?

A. It is a standard of practice if the pathologist is alert to some possibility of abnormality that he probably would naturally do that.

Q. So if the technologist makes her circles on the slide and the pathologist is now looking at this and the circles would indicate some sort of abnormality that she, he perceived, then he would or it would be the standard of practice for him not only to look at what was in the circles but what else was on the slide?

A. I would agree that most practicing pathologists would do that, just sort of naturally.

Q. Now, is it also the or would it be the standard of practice for a cytotechnologist to track

prior slides to compare with the present slides or is that something that isn't normally within the standard and practice for that person to do?

A. I think that my answer to that question is that generally the responsibility is at the top and if that were her job and directed as such and she wasn't performing it that would be one matter but if she was not directed to do that it would not -- I would not consider that in her realm of responsibility.

Q. So it would be incumbent upon the pathologist then to say to her or he or him, whatever, to yet the prior slides and would she compare them or would the pathologist then compare them?

A. They both can do that.

Q. They can both do that?

A. They can both do that but I think that the ultimate responsibility rests on pathologists for directions of that type.

Q. To direct her to do that? Or him?

A. That would be how I would interpret that, yes.

Q. All right.

MS. SFISCKO: That's all. I have no other questions. Thank you.

MR. KAMPINSKI: I have two

follow-ups, just those few questions, Doctor,

- - - -

FURTHER CROSS-EXAMINATION OF ERWIN R. RABIN, M.D.

BY MR. **KAMPINSKI**:

Q. Were any of the abnormalities that you pointed out on your slides within the circles?

A. Oh, **I** think so.

Q. Were they?

A. Oh, I think so.

Q. We just didn't see the circles on the slides?

A. No, you wouldn't see them because obviously --

Q. Okay.

A. -- the magnifications would be higher than those circles. You'd have to go to a low mag to see the circles.

Q. And were you provided with either the deposition or any summary of testimony **of** Mr. --

MS. **SFISCKO**: Biggs.

Q. -- Biggs?

MR. GROEDEL: No.

Q. You don't even know who he is, I assume?

A. **No**, sir. That's one **I** didn't have to read.

Q. **If**, in fact, you as a pathologist delegate

certain tasks to one of your employees who is also employed at the hospital --

A. They're generally employees of the hospital.

Q. But they do provide services to you and you, in fact --

A. They professionally are -- we're responsible for their professional performance.

Q. Okay. Well, as employees of the hospital, the hospital's also responsible for their performance?

A. Absolutely, yes.

Q. And if you delegate a responsibility to one of those employees, for example, to obtain prior slides for comparison when there has been an abnormality and you rely on them to do that, sure, you are the captain of the ship and you are ultimately responsible, but they're still responsible for following your instructions, are they not?

MR. GROEDEL: Objection. Go ahead.

A. I would assume that if I ask them to do that and it was consistent with one of their job responsibilities that they would do that. If they didn't do that I'd probably certainly find

them not responsible in that particular area and --

Q. You mean responsible?

A. Yes. I think that I would ask them to do it, I would expect them to do it. If they don't do it, I would consider that less than optimal performance, if you would.

Q. Substandard performance, actually?

A. Yes. I have no problem with that word.

Q. Okay.

MR. KAMPINSKI: That's all I have.

MS. SFISCKO: I have nothing else.

MR. GROEDEL: Okay.

_____

ERWIN R. RABIN, M.D.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Aneta I. Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named ERWIN R. RABIN, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 __.

_____
Aneta I. Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 27, 1996

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EXHIBIT INDEX

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